NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

MH/DD/SAS Community Systems Progress Indicators

Report for First Quarter SFY 2006-2007

July 1 – September 30, 2006

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Quality
NC DMH/DD/SAS

*What we are witnessing today is a shift toward holding **human service systems** accountable for the benefits (or lack thereof) at the consumer level. …With [this] shift, measures have broadened and have begun to focus on consumer outcomes that are related to specific provider organizations and practitioners. Outcomes measures themselves are undergoing modification with less emphasis on diagnoses and symptoms and greater emphasis on recovery and resilience. The view of "the consumer" also is undergoing change with less emphasis on the individual and greater emphasis on the functional ecology of the individual (e.g. family, friends, neighborhood, community).*

…

Obviously, the transformation process calls for sustained leadership and will result in new roles in state systems and bureaucracies. Decision support data systems are essential to the entire process, so decisions can be made on the basis of better and better outcomes for children, families, and adults. Form will follow function. We cannot have new (better) outcomes by doing the same old thing. We need to go into the transformation process with clear purpose, a thoughtful approach, and excellent sources of data related to the overall mission and goals of the system being transformed. We need to expect and plan for organizational and system change. With practice, we can learn how to initiate and manage change effectively, we can learn how to implement innovations to achieve maximum benefits for consumers, and we can develop new services system infrastructures specifically designed to support excellence as practitioners work with consumers. With practice, our approach to transformation will be come well entrenched and the benefits to consumer will improve with each generation.

FromThe ImpleNet Quarterly e-Newsletter, National Implementation Research Network, Louis de la Parte Florida Mental Health Institute, University of South Florida. October 2006.

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Introduction

Effective management of community systems is essential for the success of North Carolina's efforts to transform its mental health/developmental disabilities/substance abuse service (MH/DD/SAS) system. Tracking the status and progress of community systems provides a means for the public and General Assembly to hold the Division of MH/DD/SAS and its Local Management Entities (LMEs) accountable for progress toward the goals of the system reform. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.

The following pages report local progress on key indicators of an effective and responsive service system, as defined by the goals of North Carolina's system transformation efforts and federal initiatives.[1] These indicators measure each local system's progress in three areas:

- Service Delivery
- Service Quality
- System Management

Within each of these areas, the Division has selected indicators to gauge problems and progress on reform goals. Each area covered by these indicators involves substantial "behind-the-scenes" activity by service providers, LME and state government staff, consumers, and family members. These indicators do not purport to cover all of those efforts. Instead, they provide critical highlights that can guide analysis by the public, the General Assembly, and local and state managers into more detailed issues that affect progress toward the goals of MH/DD/SAS system transformation. The indicators, along with the rationale for their use, are presented in Table 1 below.

Table 1: Rationale for Progress Indicators

Progress Area	Indicator	Rationale
Service Delivery	1. Services to Persons In Need (Treated Prevalence)[2]	NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance.

[1] This report fulfills the requirements of House Bill 2077 that directs the Department of Health and Human Services to develop critical indicators of LME performance. Measures reflect the goals of the NC State Plans 2000-2006, the President's New Freedom Initiative, CMS' Quality Framework for Home and Community Based Services, and SAMHSA's Federal Action Agenda and National Outcome Measures.

[2] *Prevalence* is defined as the percent of the population estimated to have a particular condition within a given year. *Treated prevalence* is the percent of the population who receive services for that condition within a year.

Progress Area	Indicator	Rationale
	2. Timely initiation and engagement in service	National standards for initiating and continuing care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service).[3] These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.
	3. Effective use of state psychiatric hospitals	State psychiatric hospitals provide a safety net for the community service system. An adequate community system can and should provide their residents with crisis and short-term inpatient care close to home. This helps families stay in touch and reserves high-cost state facility beds for consumers with long-term care needs. Reducing the short-term use of state psychiatric hospitals is a goal that also allows more effective and efficient use of funds for community services.
	4. Timely follow-up after inpatient care	Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community supports. A community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[3]
Service Quality	5. Consumer choice of service providers	A system that offers consumers an array of providers supports the development of successful practitioner-consumer relationships which, in turn, foster recovery and stability. Consumer choice can also improve the quality of the entire service system, as providers strive to satisfy consumers.
	6. Use of evidence-based service models and best practices	Quality care is care that makes a real difference in an individual's life. Service models and practices that have been tested for effectiveness provide the greatest opportunity for individuals to attain stability in their lives. NC is promoting adoption of evidence-based practices in community service systems.

[3] Health Plan Employer Data and Information Set (HEDIS®) measures.

Progress Area	Indicator	Rationale
System Management	7. Implementation of management functions	The success of a community service system depends on effective management. The LMEs have been charged with eight management areas: Governance and Administration, Business Management, Provider Relations, Customer Service & Consumer Affairs, Service Management, Quality Management, Claims Adjudication, and Screening, Triage & Referral (STR). Full implementation of these functions is critical for making progress toward the goals of NC's system transformation efforts.
	8. Involvement of consumers and family members in the local system	The vibrancy of the local Consumer and Family Advisory Committees (CFACs) provides an indication of the responsiveness of the local system and its effectiveness in meeting the needs of residents and consumers. An engaged CFAC membership, with balanced representation across disabilities, is necessary for the LME to hear and respond to the needs of its community.
	9. Effective management of service funds	Stretching limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.
	10. Effective management of information	Efficient flow of information is vital for effective decision making and oversight of a complex service system. Timely submission of consumer information is a gauge of the management and coordination capacity of the local system and the technological resources available to support it.

The information in this report complements the Quarterly DHHS-LME Performance Contract Reports, which evaluates each LME's compliance with 30 contractual items. *Indicator 4: Timely Follow-up Care after Inpatient Care* in the table above is replacing the measure previously used in the Performance Contract Reports. The data for *Indicator 10: Effective Management of Information* will continue to appear in both reports.

This inaugural report includes data on those measures for which valid indicators and dependable data have previously been developed. These are addressed in Table1 above. The report also includes placeholders for measures in development, which are addressed in Table 2 below.

Table 2: Indicators in Development

Progress Area	Indicator	Rationale
Service Delivery	1. Timely access to services	When an individual makes a request for service, quick response with the appropriate level of care is a gauge of the system's service capacity and coordination. National standards for access include providing care within two hours of request in emergency situations, within 48 hours in urgent situations, and within 7 days in non-urgent situations.[4]
Service Quality	2. Person-centered planning and delivery of services	Recovery and community stability hinge on designing services to meet the needs of each individual. A timely, comprehensive service plan developed collaboratively by a consumer and his or her providers with help from family, friends, and supporters is crucial to designing and delivering individualized services. Increasing the number of consumers with person-centered plans is a means to this end.
	3. Effective oversight of service quality	Local oversight of community services is essential for risk management and continuous improvement of the quality of care. LMEs' assessment of their providers' strengths and areas of need can guide technical assistance activities effectively. Increasing oversight to those providers with the greatest need for assistance improves the quality of the choices available to consumers.

Over the course of the current state fiscal year, the Division will be working with a consultant to refine indicators and put in place mechanisms to track indicators in development. In addition, the Division will develop measures on:

- LME responsiveness to consumer complaints
- LME community collaboration activities

The following pages present graphs showing the progress of each LME on the ten selected indicators. Tables showing the statistics for each LME on the indicators are available in a separate document, the *Community Systems Progress Indicators Report Appendix*.[5] Both are available on the Division website at:

http://www.dhhs.state.nc.us/mhddsas/

[4] Health Plan Employer Data and Information Set (HEDIS®) measures.

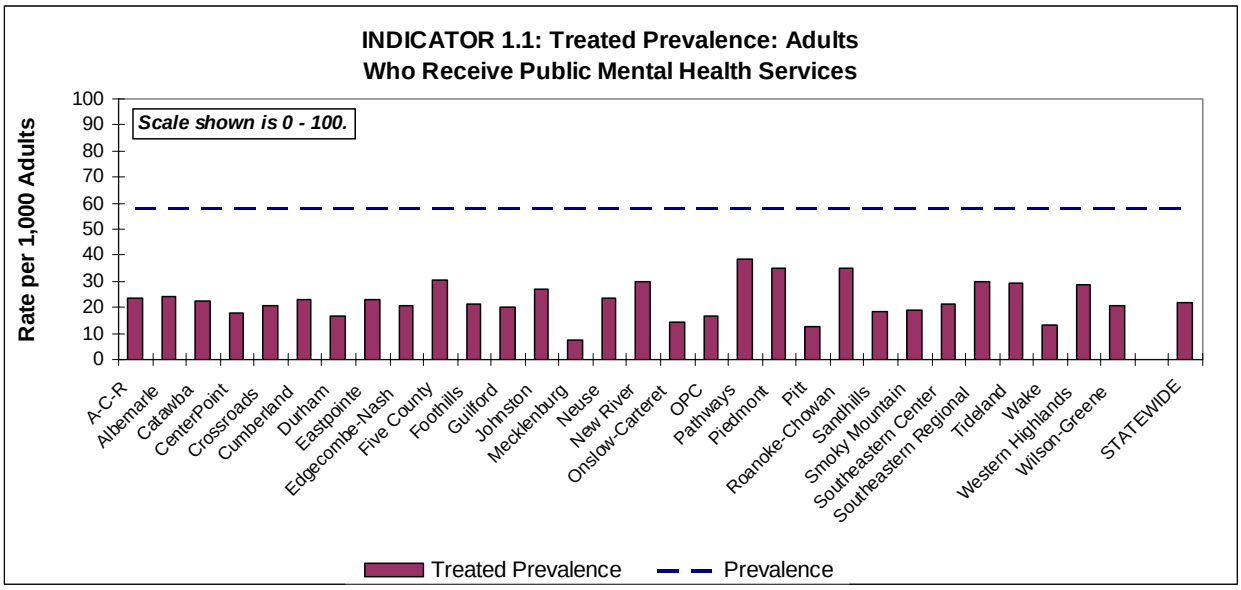
[5] A list of counties that make up each LME is available in the Report Appendix.

Service Delivery

Indicator 1: Services to Persons in Need

1.1 Adult Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data; Piedmont Encounter Data. July 1, 2005 - June 30, 2006

Almost sixty out of every 1,000 adults (5.8%) in North Carolina experience a severe or severe and persistent mental illness (SMI or SPMI) in any given year.[6] Statewide, approximately 22 of every 1,000 adults received publicly-funded MH services through our community service system in SFY 2005-06.[7] The rate of adults who were served varied among LMEs from a low of 8 adults per 1,000 (Mecklenburg) to a high of 39 adults per 1,000 (Pathways).[8]

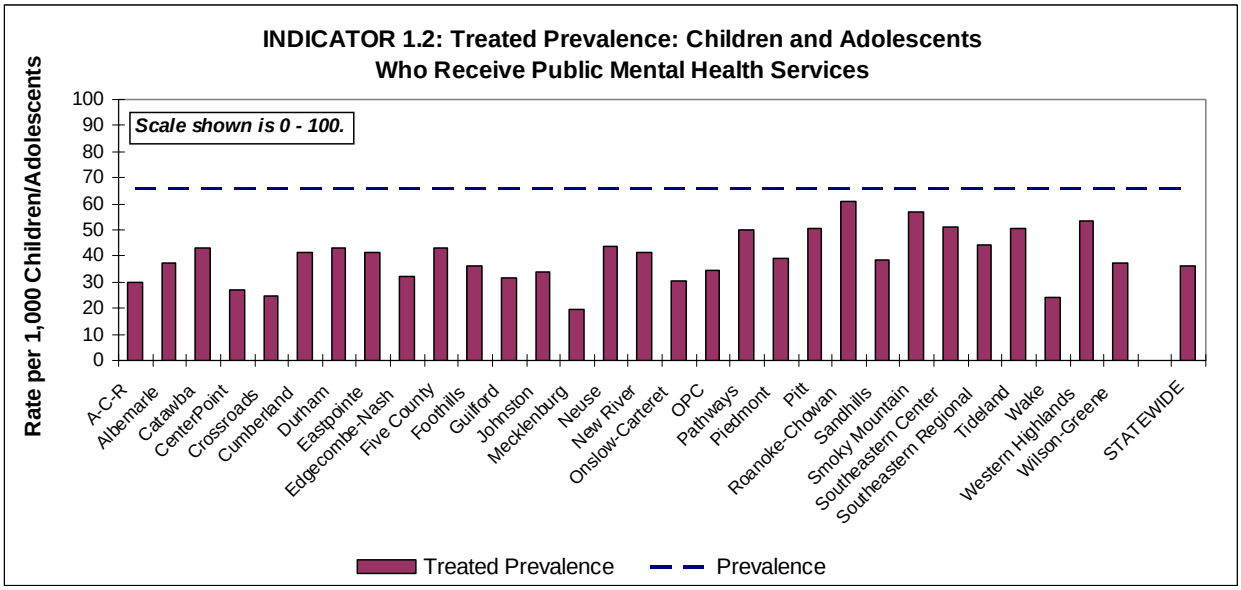
[6] *Gap Analysis and Final Summary Report.* Unpublished document prepared for NC DMH/DD/SAS by Heart of the Matter, Inc. and Pareto Solutions, LLC. September 2006. Prevalence rates for SMI and SPMI vary across LMEs due to population density and other factors, from a low of 4.5% (Roanoke-Chowan) to a high of 7.0% (Cumberland). See the Appendix for LME-specific rates.

[7] The numbers reflect adults, ages 18 and over, who received any MH services (including assessments) in the community system, regardless of diagnosis. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private funds.

[8] Mecklenburg's numbers may be underreported due to problems in their information technology system.

Indicator 1: Services to Persons in Need
1.2 Child and Adolescent Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data; Piedmont Encounter Data. July 1, 2005 - June 30, 2006

Over sixty out of every 1,000 children and adolescents (6.6%) in North Carolina experience severe emotional disturbances (SED) in any given year.[9] Statewide, approximately 36 of every 1,000 children and adolescents received publicly-funded MH services through our community service system in SFY 2005-06.[10] The rate of those served varied among LMEs from a low of 20 children and adolescents per 1,000 (Mecklenburg) to a high of 61 children and adolescents per 1,000 (Roanoke-Chowan).[11]

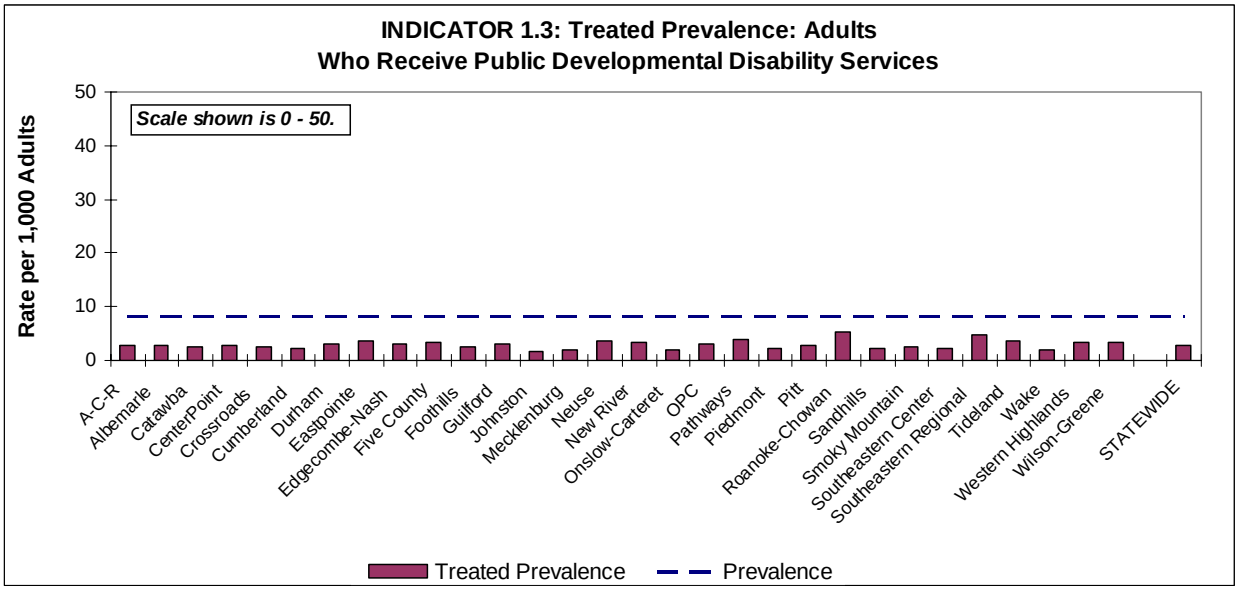
[9] *Gap Analysis and Final Summary Report.* Unpublished document prepared for NC DMH/DD/SAS by Heart of the Matter, Inc. and Pareto Solutions, LLC. September 2006.

[10] The numbers reflect children and adolescents, ages 0-17, who received any MH services (including assessments) in the community system, regardless of diagnosis. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private funds.

[11] Mecklenburg's numbers may be underreported due to problems in their information technology system.

Indicator 1: Services to Persons in Need
1.3 Adult Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data; Piedmont Encounter Data. July 1, 2005 - June 30, 2006

Approximately eight out of every 1,000 adults (0.8%) in North Carolina have a developmental disability that requires supportive services.[12] Statewide, approximately 3 of every 1,000 adults received publicly-funded DD services through our community service system in SFY 2005-06.[13] The rate of adults who were served varied among LMEs from a low of less than 2 adults per 1,000 (Johnston, Mecklenburg, and Wake) to a high of over 5 adults per 1,000 (Roanoke-Chowan).[14]

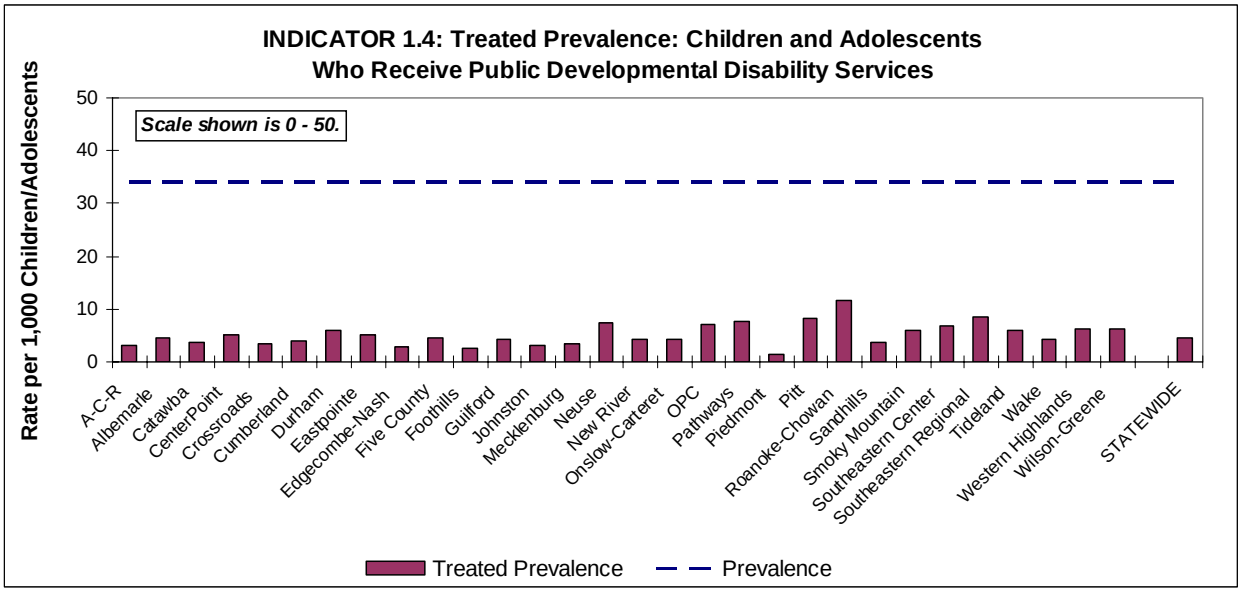
[12] *Gap Analysis and Final Summary Report.* Unpublished document prepared for NC DMH/DD/SAS by Heart of the Matter, Inc. and Pareto Solutions, LLC. September 2006.

[13] The numbers reflect adults, ages 18 and over, who received any DD services (including assessments) in the community system, regardless of diagnosis. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

[14] Mecklenburg's numbers may be underreported due to problems in their information technology system.

Indicator 1: Services to Persons in Need
1.4 Child and Adolescent Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data; Piedmont Encounter Data. July 1, 2005 - June 30, 2006

Over thirty out of every 1,000 children and adolescents (3.4%) in North Carolina have a developmental disability that requires supportive services.[15] Statewide, almost 5 of every 1,000 children and adolescents received publicly-funded DD services through our community service system in SFY 2005-06.[16] [17] The rate of those who were served varied among LMEs from a low of less than 2 children and adolescents per 1,000 (Piedmont) to a high of 12 children and adolescents per 1,000 (Roanoke-Chowan).[18]

[15] *Gap Analysis and Final Summary Report.* Unpublished document prepared for NC DMH/DD/SAS by Heart of the Matter, Inc. and Pareto Solutions, LLC. September 2006.

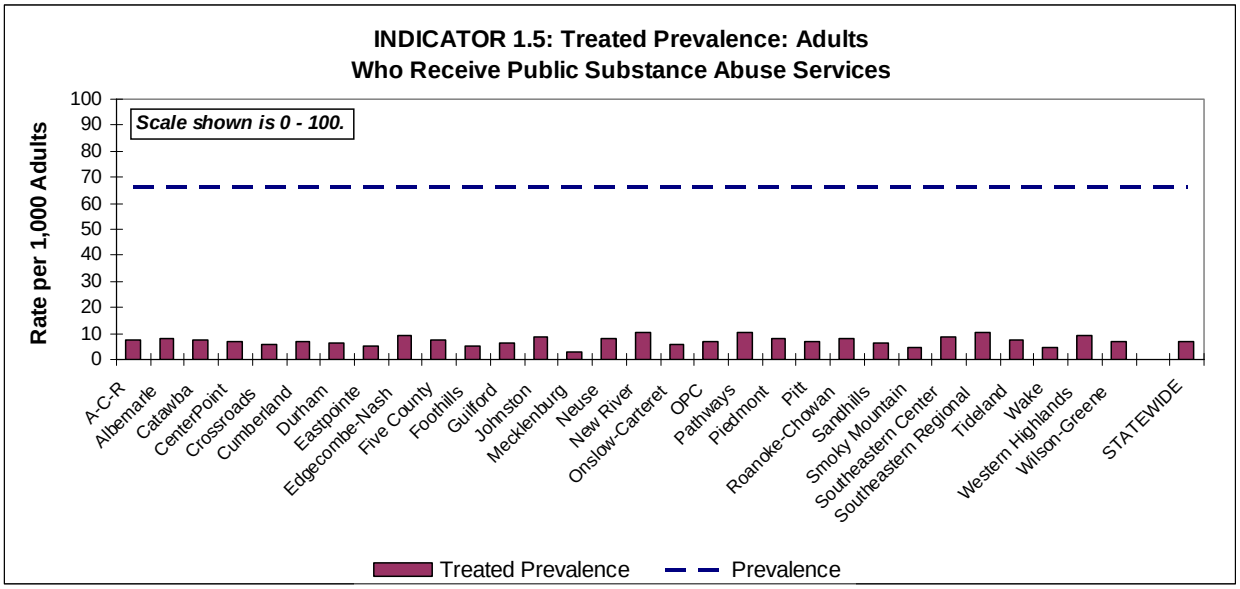
[16] The numbers reflect children and adolescents, ages 3-17, who received any DD services (including assessments) in the community system, regardless of diagnosis. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

[17] The NC Division of Public Health is responsible for all services from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21.

[18] Mecklenburg's numbers may be underreported due to problems in their information technology system.

Indicator 1: Services to Persons in Need
1.5 Adult Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data; Piedmont Encounter Data. July 1, 2005 - June 30, 2006

Over sixty out of every 1,000 adults (6.6%) in North Carolina experience a serious substance abuse problem in any given year.[19] Statewide, approximately 7 of every 1,000 adults received publicly-funded SA services through our community service system in SFY 2005-06.[20] The rate of adults who were served varied among LMEs from a low of 3 adults per 1,000 (Mecklenburg) to a high of over 10 adults per 1,000 (New River, Pathways, and Southeastern Regional).[21]

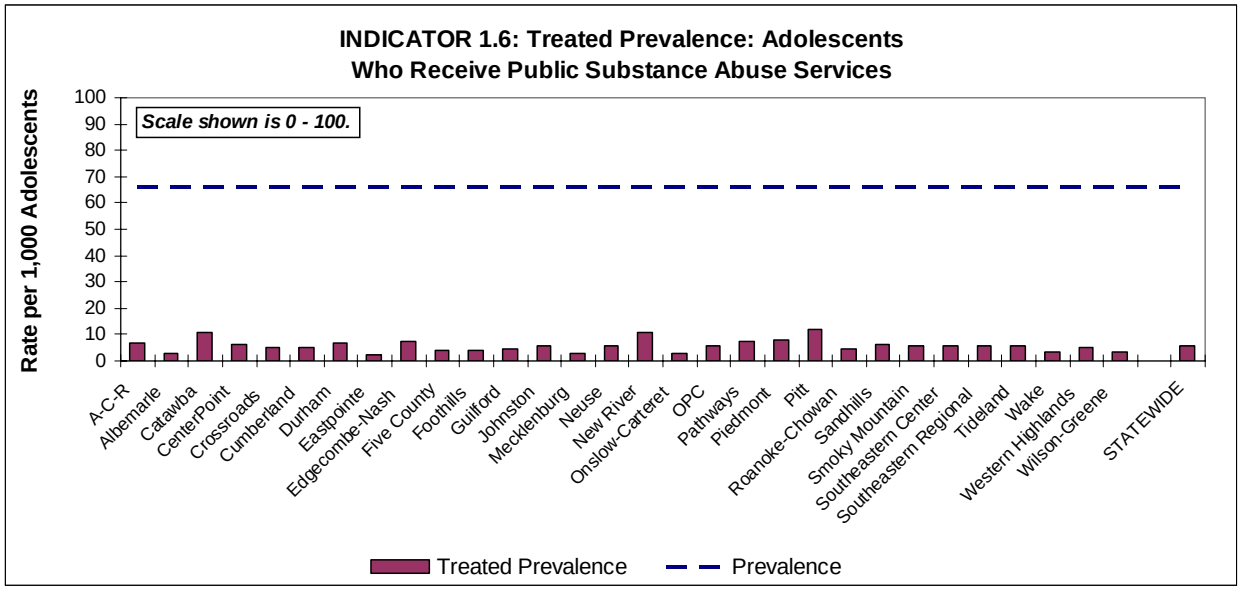
[19] *Gap Analysis and Final Summary Report.* Unpublished document prepared for NC DMH/DD/SAS by Heart of the Matter, Inc. and Pareto Solutions, LLC. September 2006.

[20] The numbers reflect adults, ages 18 and over, who received any SA services (including assessments) in the community system, regardless of diagnosis. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

[21] Mecklenburg's numbers may be underreported due to problems in their information technology system.

Indicator 1: Services to Persons in Need
1.6 Adolescent Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data; Piedmont Encounter Data. July 1, 2005 - June 30, 2006

Over sixty out of every 1,000 adolescents (6.6% of those ages 12-17) in North Carolina experience a serious substance abuse problem in any given year.[22] Statewide, approximately 5 of every 1,000 adolescents received publicly-funded services through our community service system.[23] The rate of targeted adolescents who were served varied among LMEs from a low of 2 adolescents per 1,000 (Eastpointe) to a high of 12 adolescents per 1,000 (Pitt).[24]

[22] *Gap Analysis and Final Summary Report.* Unpublished document prepared for NC DMH/DD/SAS by Heart of the Matter, Inc. and Pareto Solutions, LLC. September 2006.

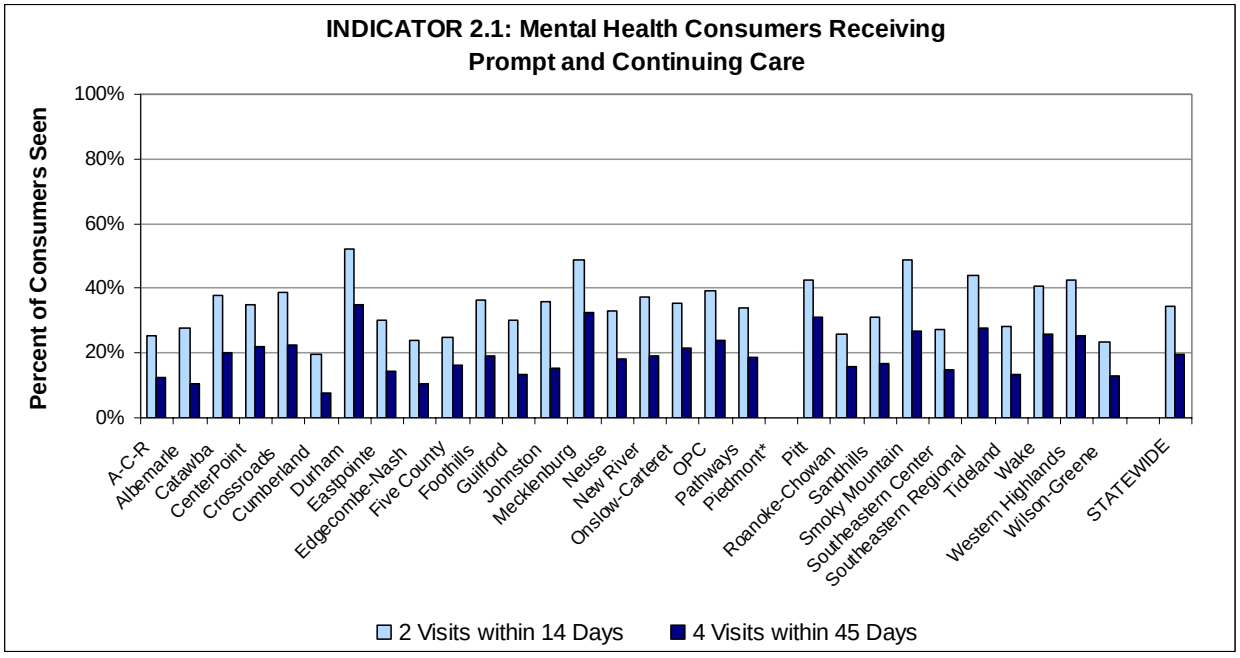
[23] The numbers reflect adolescents, ages 12-17, who received any SA services (including assessments) in the community system, regardless of diagnosis. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

[24] Mecklenburg's numbers may be underreported due to problems in their information technology system.

Indicator 2: Timely Initiation and Engagement in Service

2.1 Mental Health Services

Rationale: National standards for initiating and continuing care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2006 (first service received)

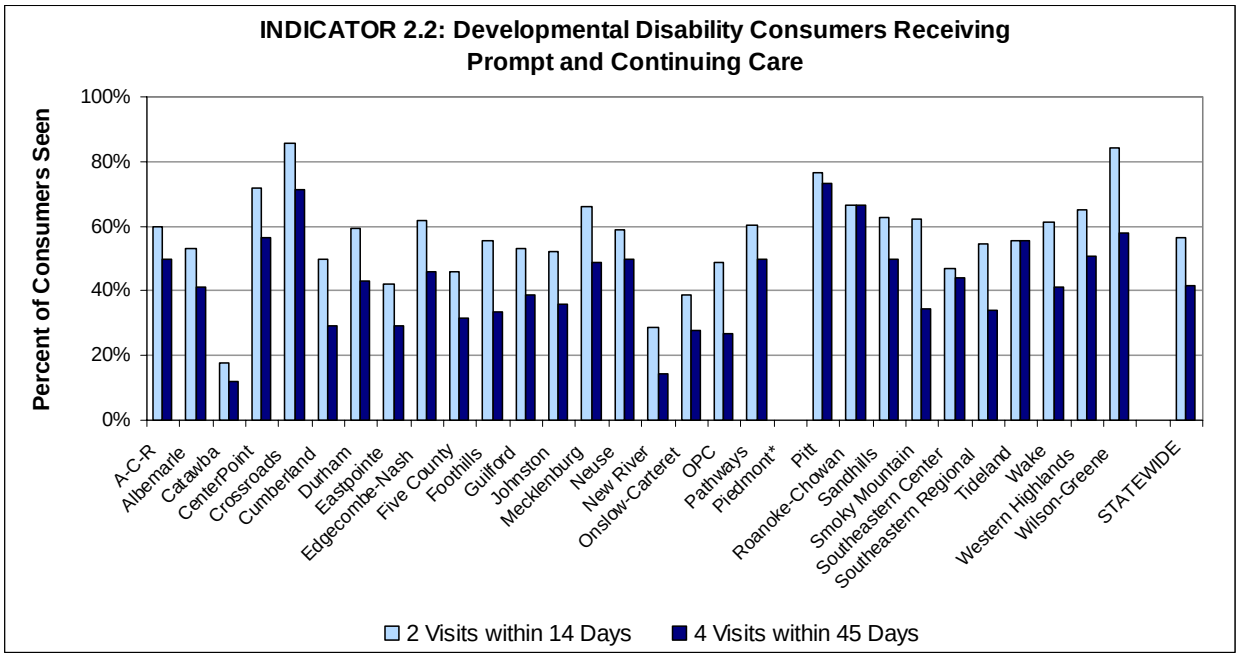
Approximately 34% of NC residents (all age groups) who receive mental health services have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 19% (Cumberland) to a high of 52% (Durham). Compared to the other disability groups, consumers with mental illness are waiting longer on average for initiation of care.

Approximately 19% of mental health consumers have an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 8% (Cumberland) to a high of 35% (Durham).

** Data on service claims for Piedmont are not available for this report.*

Indicator 2: Timely Initiation and Engagement in Service
2.2 Developmental Disability Services

Rationale: National standards for initiating and continuing care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2006 (first service received)

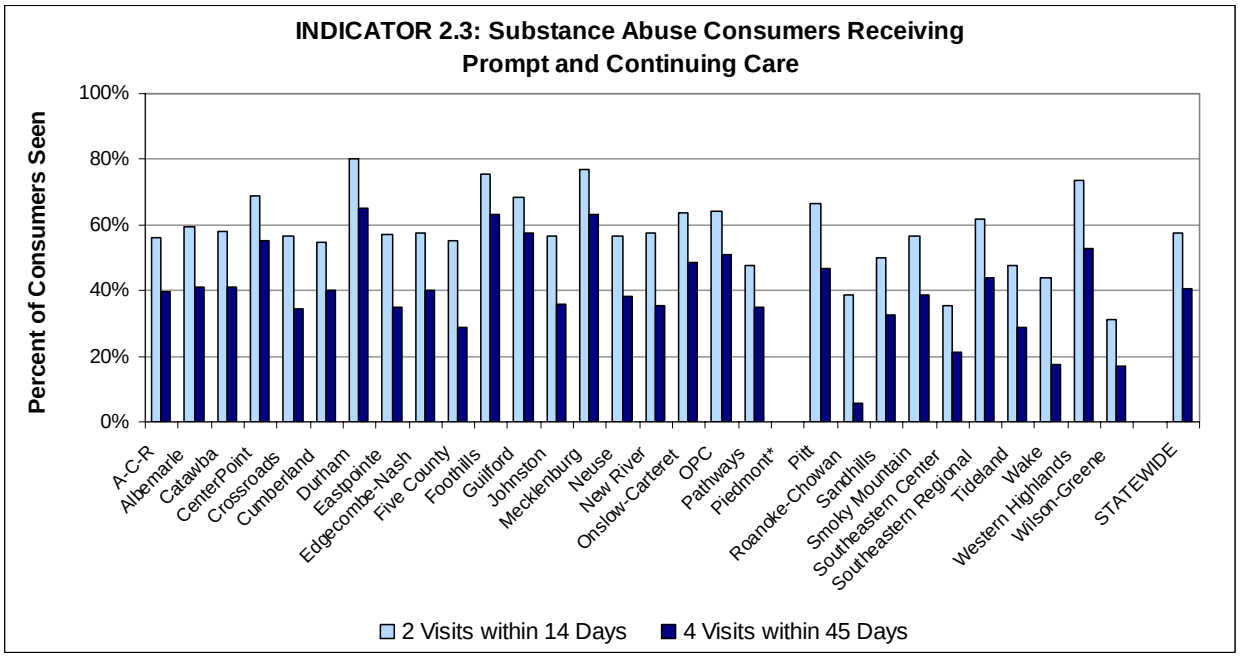
About 56% of NC residents (all age groups) who receive developmental disability services/supports have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 18% (Catawba) to a high of 86% (Crossroads).

Approximately 41% of developmental disability consumers have an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 12% (Catawba) to a high of 73% (Pitt).

** Data on service claims for Piedmont are not available for this report.*

Indicator 2: Timely Initiation and Engagement in Service
2.3 Substance Abuse Services

Rationale: National standards for initiating and continuing care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2006 (first service received)

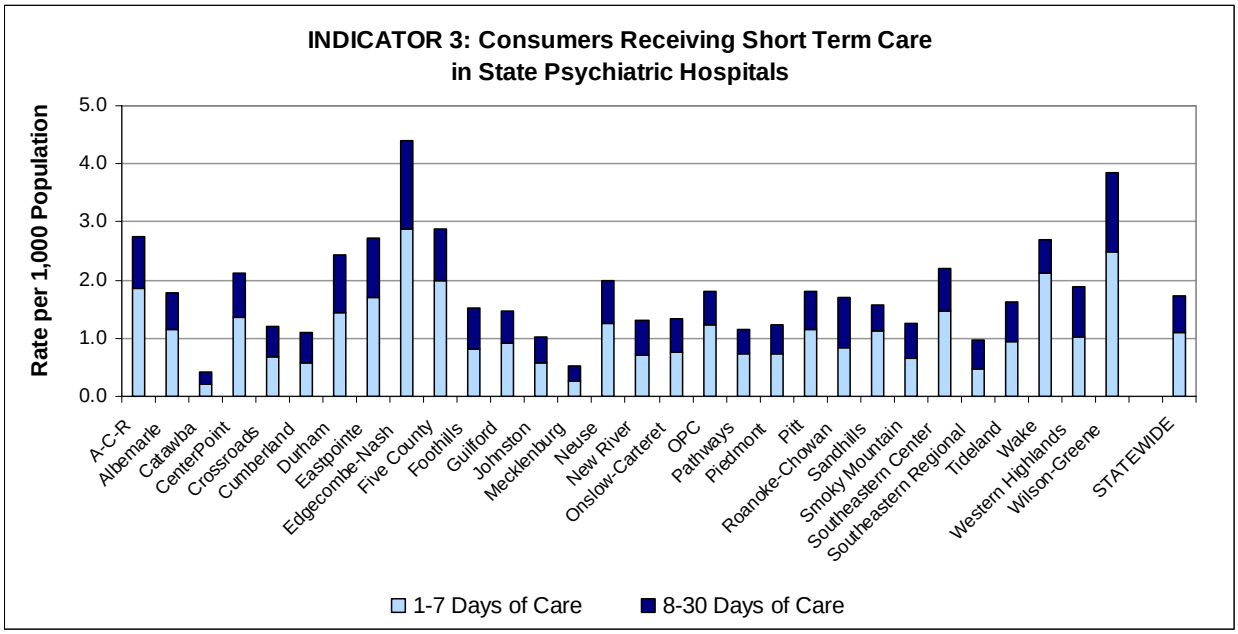
About 58% of NC residents (all age groups) who receive substance abuse services have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 31% (Wilson-Greene) to a high of 80% (Durham).

Approximately 40% of substance abuse consumers have an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 6% (Roanoke-Chowan) to a high of 65% (Durham).

** Data on service claims for Piedmont are not available for this report.*

Indicator 3: Effective Use of State Psychiatric Hospitals

Rationale: State psychiatric hospitals provide a safety net for the community service system. An adequate community system can and should provide their residents with crisis and short-term inpatient care close to home. This helps families stay in touch and reserves high-cost state facility beds for consumers with long-term care needs. Reducing the short-term use of state psychiatric hospitals is a goal that also allows more effective and efficient use of funds for community services.



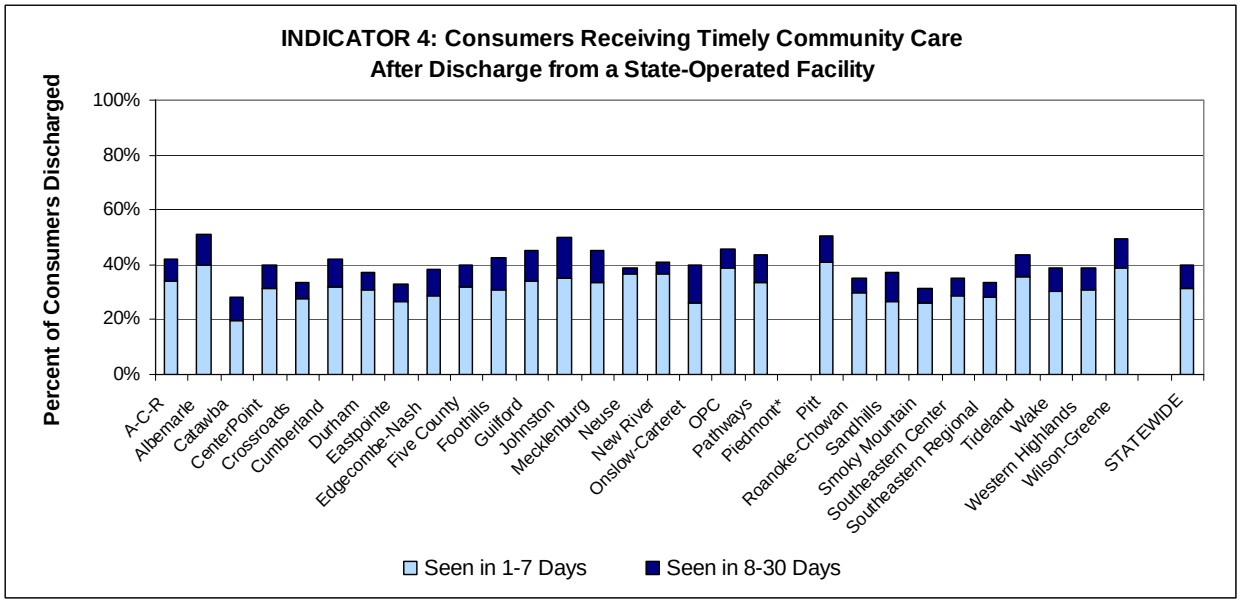
SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Admission and Discharge Data. July 1, 2005 - June 30, 2006

Statewide, 11 out of every 10,000 NC residents were hospitalized for 1-7 days (total number of statewide admissions for 1-7 days was 9,729) and 6 out of 10,000 were hospitalized for 8-30 days (total number of statewide admissions for 8-30 days was 5,483). Lengths of stay of 1-7 days varied by LME from a high rate of 29 per 10,000 (Edgecombe-Nash) to a low of 2 per 10,000 (Catawba). Lengths of stays of 8-30 days, while lower in every LME, showed a similar pattern, with Edgecombe-Nash again having the highest rate (15 per 10,000) and Catawba having the lowest (2 per 10,000).

Almost 90% of NC's admissions to state psychiatric hospitals in SFY 2005-06 were for stays of 30 days or less. As local capacity to provide crisis services increases, the Division expects the number of short-term hospitalizations in state facilities to decrease.

Indicator 4: Timely Follow-Up after Inpatient Care

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community supports. A community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[25]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data; Medicaid and State Service Claims Data. January 1 - March 31, 2006 (HEARTS discharge dates)

Statewide approximately 32% of consumers discharged from State-operated facilities received follow-up care in the community within 7 days. An additional 9% of NC consumers were seen within 8-30 days of discharge.

Among LMEs, the percent of consumers receiving follow-up care within 7 days varied from a low of 20% (Catawba) to a high of 41% (Pitt). Overall, the percent of consumers receiving follow-up care within 1-30 days varied from a low of 28% (Catawba) to a high of 51% (Albemarle and Pitt).

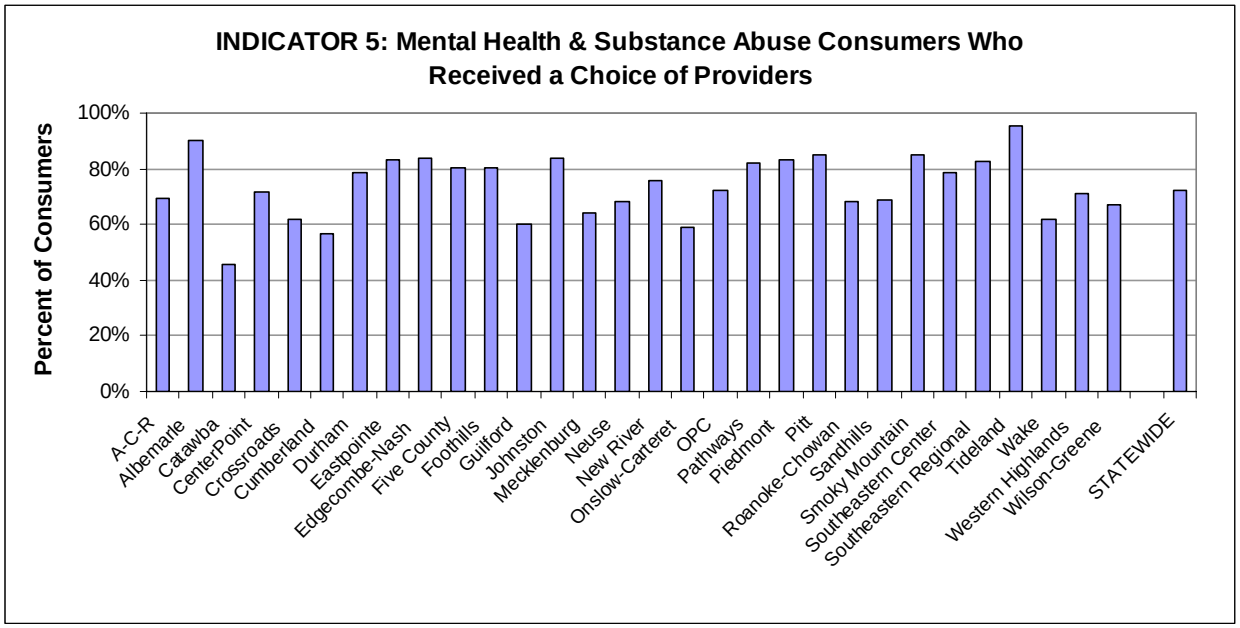
** Data on service claims for Piedmont are not available for this report.*

25 This is a Health Plan Employer Data and Information Set (HEDIS®) measure.

Service Quality

Indicator 5: Consumer Choice of Service Providers

Rationale: A system that offers consumers an array of providers supports the development of successful practitioner-consumer relationships which, in turn, foster recovery and stability. Consumer choice can also improve the quality of the entire service system, as providers strive to satisfy consumers.



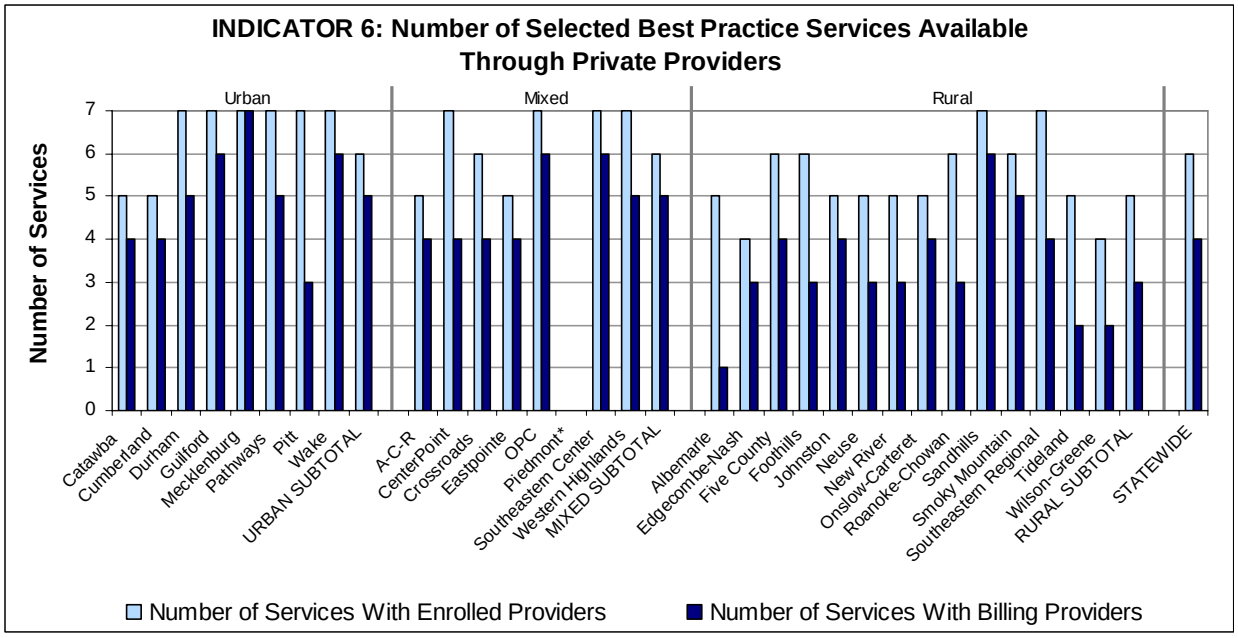
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. July 1 - September 30, 2006

Statewide, over 70% of MH and SA consumers reported receiving options of places to receive services.[26] Among LMEs, the percent of consumers offered a choice varied from a low of 46% (Catawba) to a high of 95% (Tideland).

[26] The question in the Initial NC-TOPPS Interview reads: "Did you receive a list or options, verbal or written, of places to receive services?" Response options include "Yes, I received a list," "No, I came here on my own," and "No, I did not receive a list." Appropriate NC-TOPPS questions for DD consumers are currently being developed.

Indicator 6: Use of Evidence-Based Service Models and Best Practices

Rationale: Quality care is care that makes a real difference in an individual's life. Service models and practices that have been tested for effectiveness provide the greatest opportunity for individuals to attain stability in their lives. NC is promoting adoption of evidence-based practices in community service systems.



SOURCE: Medicaid Provider Enrollment Data and Medicaid Claims Data. March 1 - September 30, 2006

North Carolina has enrolled over 2,000 private provider agencies (other than LMEs) across the state to offer seven services that are based on best practice models:

- Community support/community support team (CS/CST)
- Assertive community treatment team (ACTT)
- Psycho-social rehabilitation (PSR)
- Intensive in-home (IIH)
- Multi-systemic therapy (MST)
- Substance abuse intensive outpatient program (SAIOP)
- Substance abuse comprehensive outpatient treatment (SACOT).

All 7 services are available in twelve LMEs, although only Mecklenburg has agencies that are currently providing all of them. Five LMEs can offer 6 of these services; ten LMEs can offer 5 of the services; and Edgecombe-Nash and Wilson-Greene offer 4 of them.

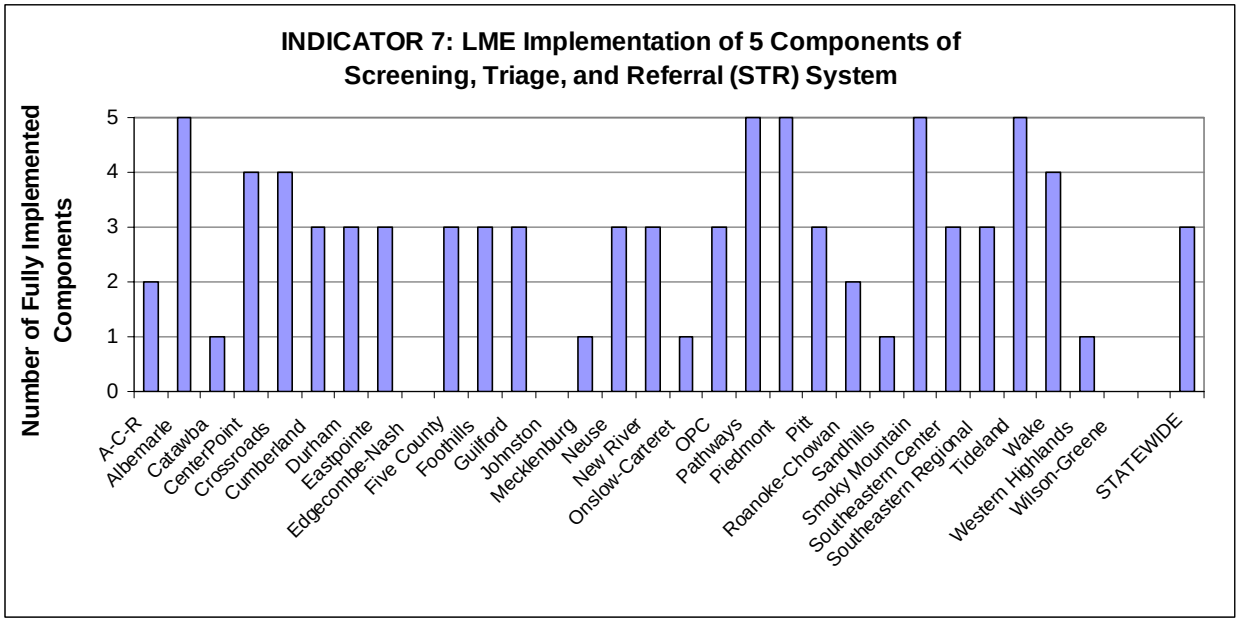
For this measure, LMEs were grouped according to their population density (See Appendix). The resulting categories – "Urban," "Mixed" and "Rural" – group LMEs who face similar challenges (e.g. transportation, numbers in need of intensive services) that might affect their provision of evidence-based services.

** Data on service claims for Piedmont are not available for this report.*

System Management

Indicator 7: Implementation of Management Functions

Rationale: The success of a community service system depends on effective management. The LMEs have been charged with eight management areas: Governance and Administration, Business Management, Provider Relations, Customer Service & Consumer Affairs, Service Management, Quality Management, Claims Adjudication, and Screening, Triage & Referral (STR). Full implementation of these functions is critical for making progress toward the goals of NC's system transformation efforts.



SOURCE: DMH/DD/SAS on-site reviews. April 2006

The LMEs' management of MH/DD/SA services in their catchment areas involves eight functions. This report evaluates their implementation of one of those functions – Screening, Triage & Referral (STR). Future reports will evaluate their status and efforts in implementing the other seven functions.

The STR function includes five components:

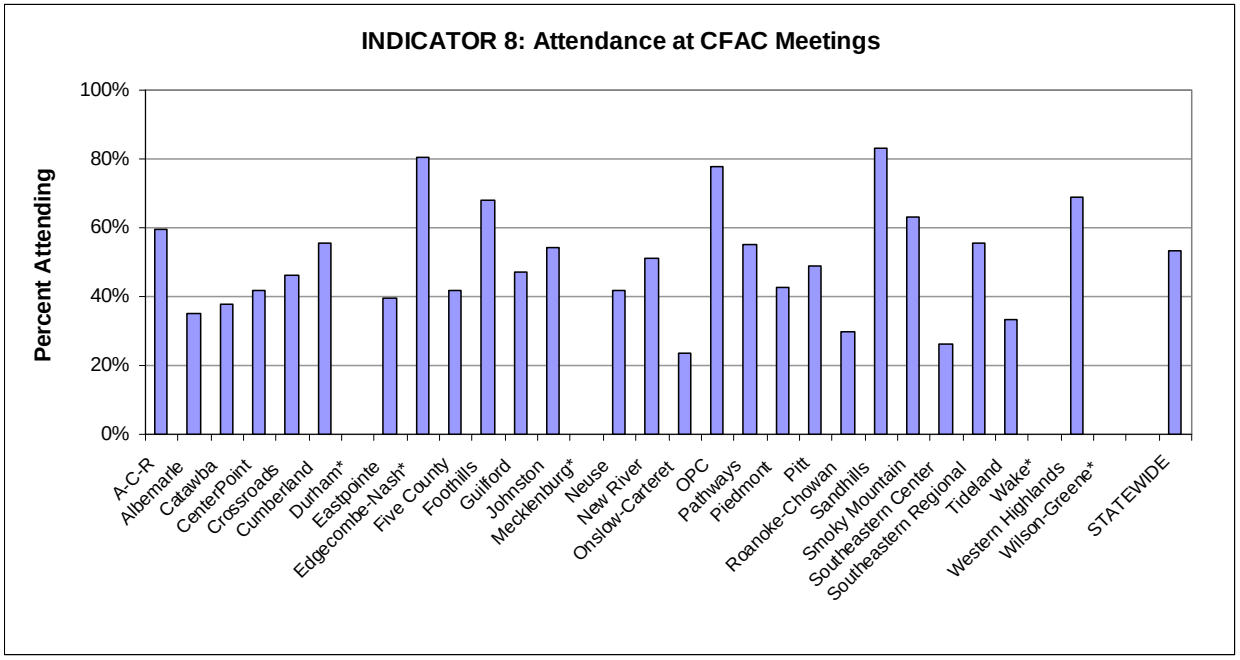
- around-the-clock access
- toll-free telephone number
- direct contact with qualified staff
- screening of individuals for type of service needed and urgency of need
- referrals to appropriate care

Five of the LMEs earned scores of 100% on all five components reviewed, indicating a fully implemented STR system.[27] Three of the remaining LMEs have fully implemented at least four of these components of their STR systems. Three LMEs (Edgecombe-Nash, Johnston, and Wilson-Greene) have not fully implemented any of these five components.

[27] At the time reviews of the STR Systems were completed, contracting of after-hours calls was allowed. However, LMEs without internal after-hours capacity are not considered to have fully implemented STR. See Appendix for details on scoring.

Indicator 8: Involvement of Consumers and Family Members in the Local System

Rationale: The vibrancy of the local Consumer and Family Advisory Committees (CFACs) provides an indication of the responsiveness of the local system and its effectiveness in meeting the needs of residents and consumers. An engaged CFAC membership, with balanced representation across disabilities, is necessary for the LME to hear and respond to the needs of its community.



SOURCE: Local CFAC meeting minutes. January 1 - March 31, 2006

Local Consumer and Family Advisory Committees (CFACs) are composed of consumers and family members representing each of the three disabilities. These committees meet monthly in all LMEs except Albemarle, where they meet every other month. Statewide, the expected membership ranges from 12 in Edgecombe-Nash and Guilford to 30 in OPC. Across the state, an average of 53% of expected members attended scheduled meetings.[28] Onslow-Carteret had the lowest average of expected attendance (24% of 24 potential members) and Sandhills had the highest (83% of 24 potential members).

** Edgecombe-Nash and Wilson-Greene share one CFAC and are reported under Edgecombe-Nash. Durham, Mecklenburg, and Wake did not set an expected number of members. Durham averaged 12 members attending, Mecklenburg averaged 11 members attending and Wake averaged 9 members attending.*

[28] Numbers in attendance include both appointed members and guests.

Indicator 9: Effective Management of Service Funds

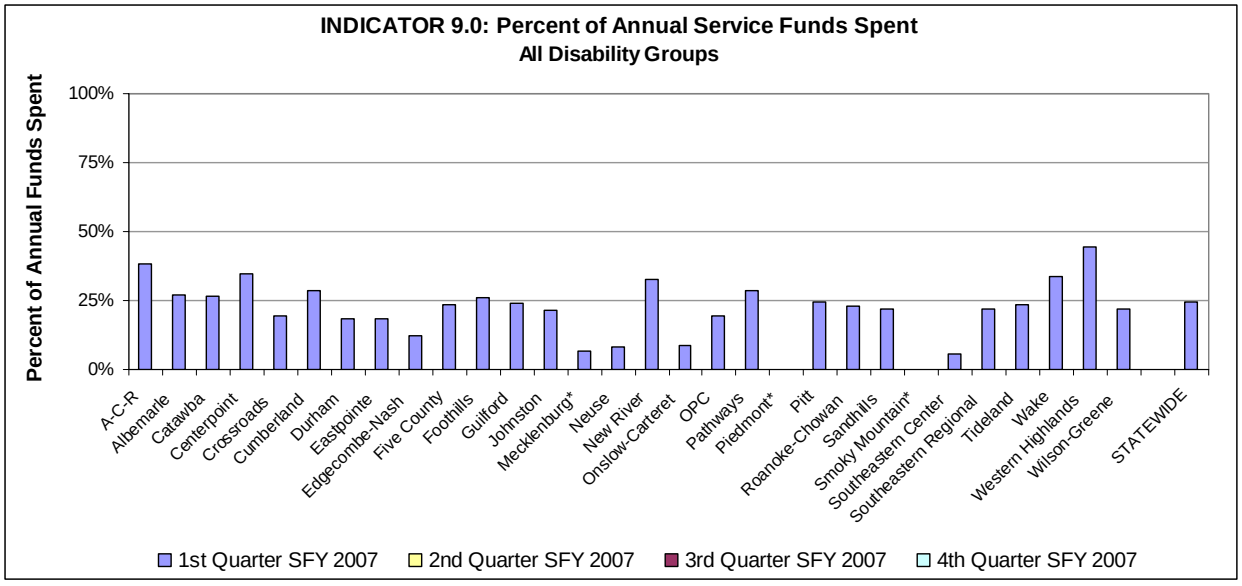
9.0 All Disability Groups

Rationale: Stretching limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

LME use of state and federal (non-Medicaid) funds can be affected by several factors, including:

- the availability and use of local funds
- the proportion of the local population eligible for Medicaid services
- unpaid service claims carried over from the previous year[29]
- local claims submission practices

Future reports will provide cumulative information on funds spent to-date in the fiscal year. Expenditures are expected to reach approximately 100% by the end of the fourth quarter.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - September 30, 2006

Across all disabilities statewide, LMEs spent approximately 24% of their LME-managed service funds during the first quarter of SFY 2006-07 (July-September 2006).[30] Expenditures vary from a low of 6% (Southeastern Center) to a high of 44% (Western Highlands). Funds expended vary much more by age-disability group.

** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

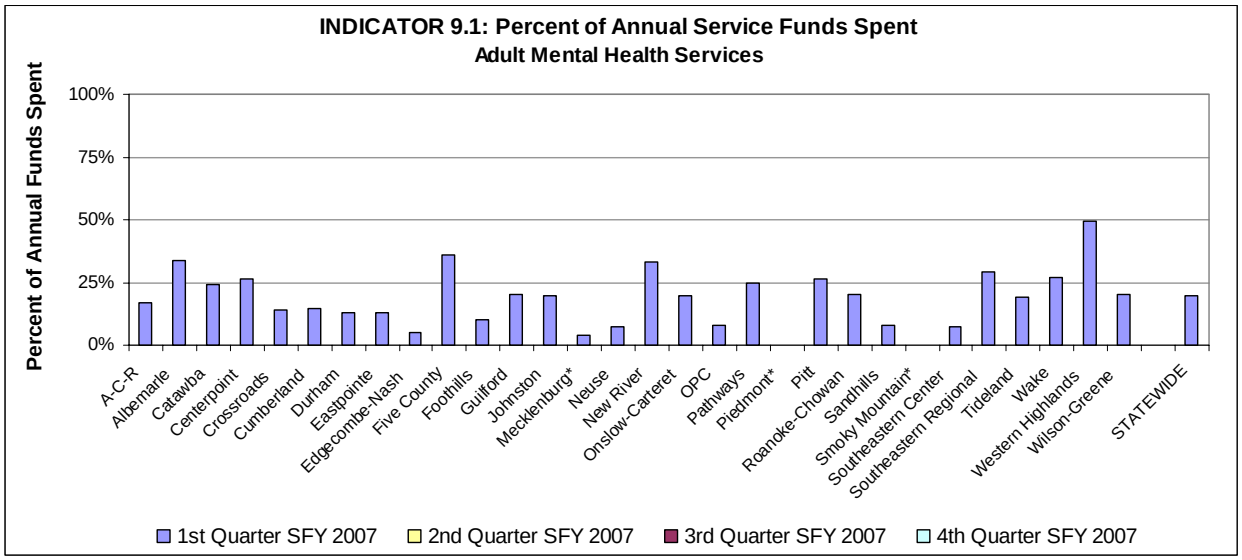
[29] Division allowed LMEs to submit claims for May and June, 2006 services through October 20, 2006. In SFY 2006-07 LMEs are allowed to shift up to 15% of State-allocated funds between age-disability groups.

[30] The numbers exclude funds processed outside of the Unit Cost Reimbursement (UCR) system.

Indicator 9: Effective Management of Service Funds
9.1 Adult Mental Health Services

Rationale: Stretching limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year. Expenditures are expected to reach approximately 100% by the end of the fourth quarter.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - September 30, 2006

Approximately 20% of SFY 2006-07 LME-managed funds for adult mental health services were expended in the first quarter of this fiscal year.[31] The percent of funds spent varied across LMEs from a low of 4% (Mecklenburg) to a high of 50% (Western Highlands).

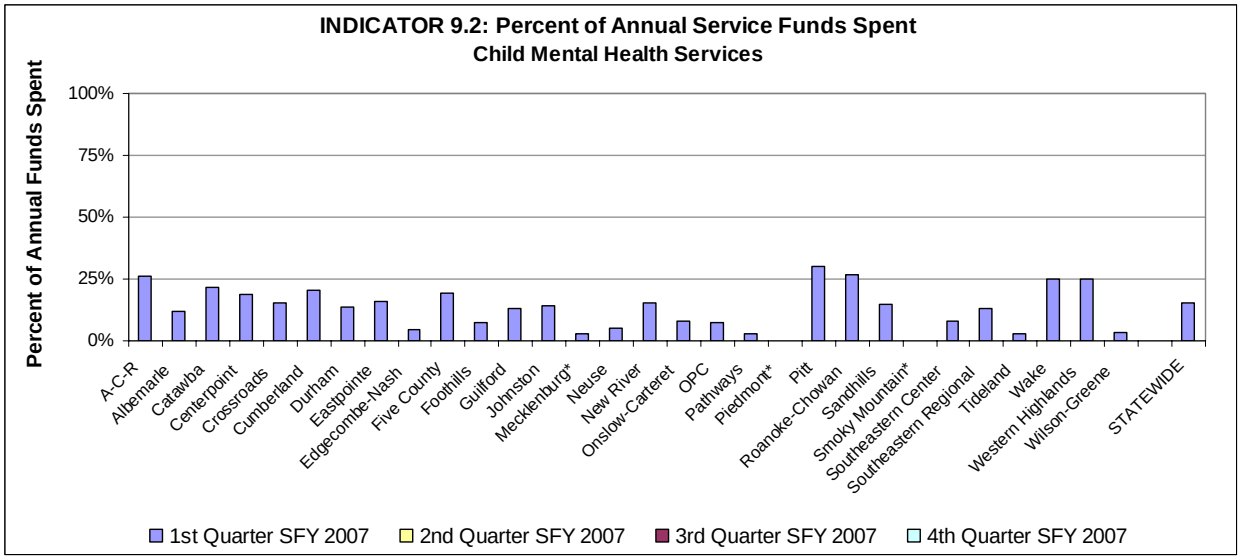
** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[31] The numbers exclude funds processed outside of the Unit Cost Reimbursement (UCR) system.

Indicator 9: Effective Management of Service Funds
9.2 Child Mental Health Services

Rationale: Stretching limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year. Expenditures are expected to reach approximately 100% by the end of the fourth quarter.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - September 30, 2006

Approximately 15% of SFY 2006-07 LME-managed funds for child mental health services were expended in the first quarter of this fiscal year.[32] The percent of funds spent varied across LMEs from a low of less than 3% (Mecklenburg, Pathways, and Tideland) to a high of 30% (Pitt).

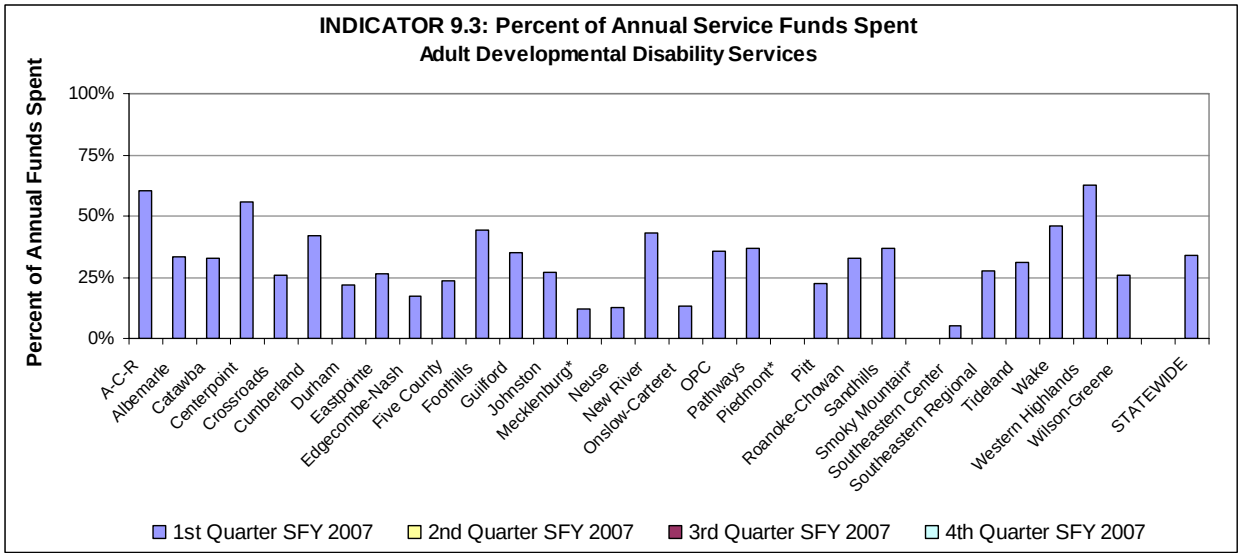
** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[32] The numbers exclude funds processed outside of the Unit Cost Reimbursement (UCR) system.

Indicator 9: Effective Management of Service Funds
9.3 Adult Developmental Disability Services

Rationale: Stretching limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year. Expenditures are expected to reach approximately 100% by the end of the fourth quarter.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - September 30, 2006

Approximately 34% of SFY 2006-07 LME-managed funds for adult developmental disability services were expended in the first quarter of this fiscal year.[33] The percent of funds spent varied across LMEs from a low of 5% (Southeastern Center) to a high of 63% (Western Highlands).

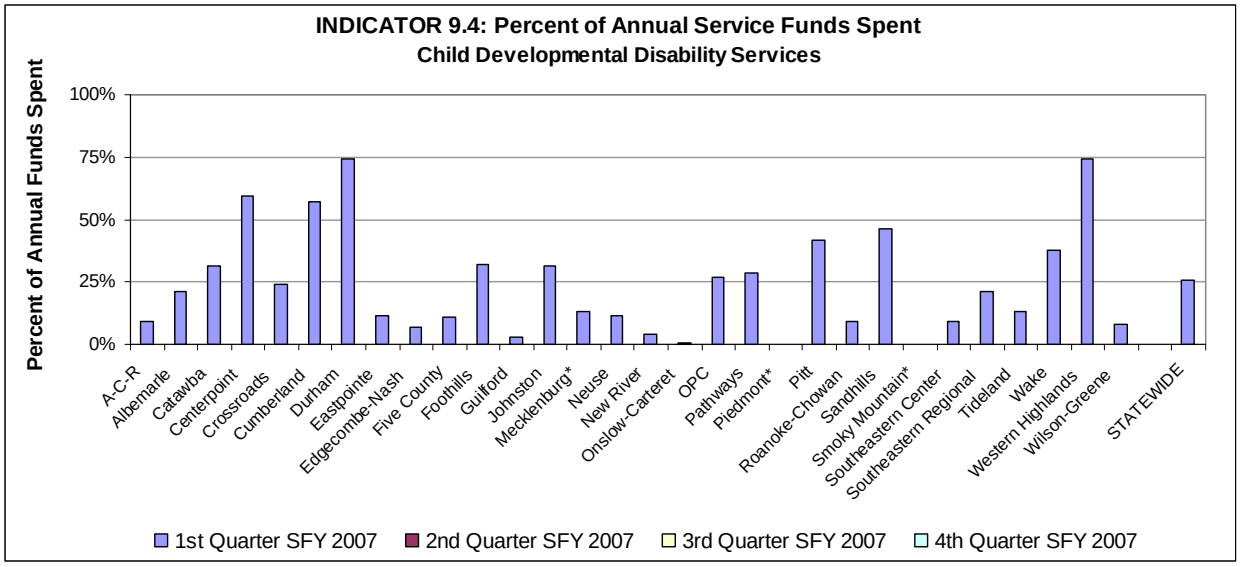
** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[33] The numbers exclude funds processed outside of the Unit Cost Reimbursement (UCR) system.

Indicator 9: Effective Management of Service Funds
9.4 Child Developmental Disability Services

Rationale: Stretching limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year. Expenditures are expected to reach approximately 100% by the end of the fourth quarter.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - September 30, 2006

Approximately 26% of SFY 2006-07 LME-managed funds for child developmental disability services were expended in the first quarter of this fiscal year.[34] The percent of funds spent varied across LMEs from a low of less than 1% (Onslow-Carteret) to a high of 75% (Durham and Western Highlands).

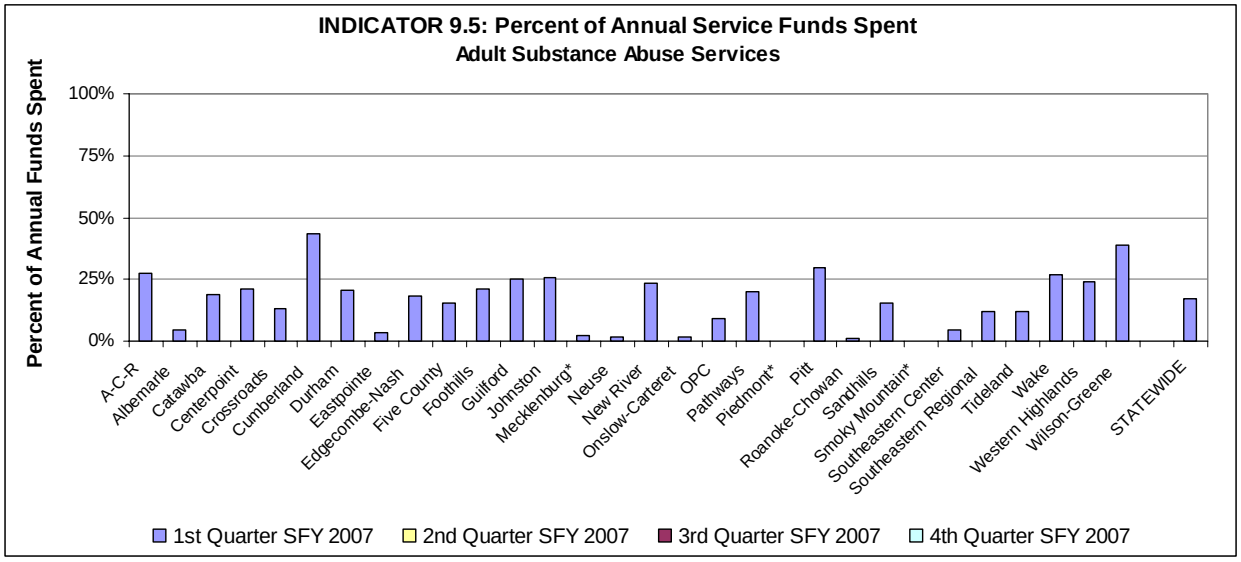
** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[34] The numbers exclude funds processed outside of the Unit Cost Reimbursement (UCR) system.

Indicator 9: Effective Management of Service Funds
9.5 Adult Substance Abuse Services

Rationale: Stretching limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year. Expenditures are expected to reach approximately 100% by the end of the fourth quarter.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - September 30, 2006

Approximately 17% of SFY 2006-07 LME-managed funds for adult substance abuse services were expended in the first quarter of this fiscal year.[35] The percent of funds spent varied across LMEs from a low of 1% (Roanoke-Chowan) to a high of 44% (Cumberland).

** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[35] The numbers exclude funds processed outside of the Unit Cost Reimbursement (UCR) system.

Indicator 9: Effective Management of Service Funds
9.6 Child Substance Abuse Services

Rationale: Stretching limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year. Expenditures are expected to reach approximately 100% by the end of the fourth quarter.

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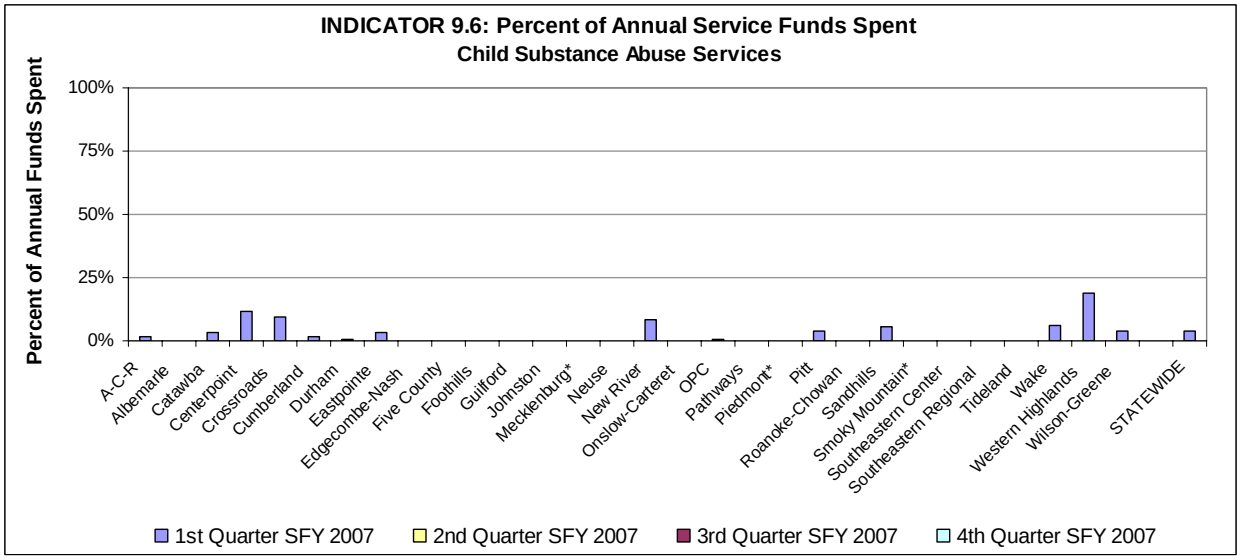


SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1 - September 30, 2006

Approximately 4% of SFY 2006-07 LME-managed funds for child substance abuse services were expended in the first quarter of this fiscal year, by far the lowest expenditures for any age-disability group.[36] Half of the LMEs spent no State funds on children with substance abuse service needs. Western Highlands, with the greatest expenditures, spent 19% of their funds.

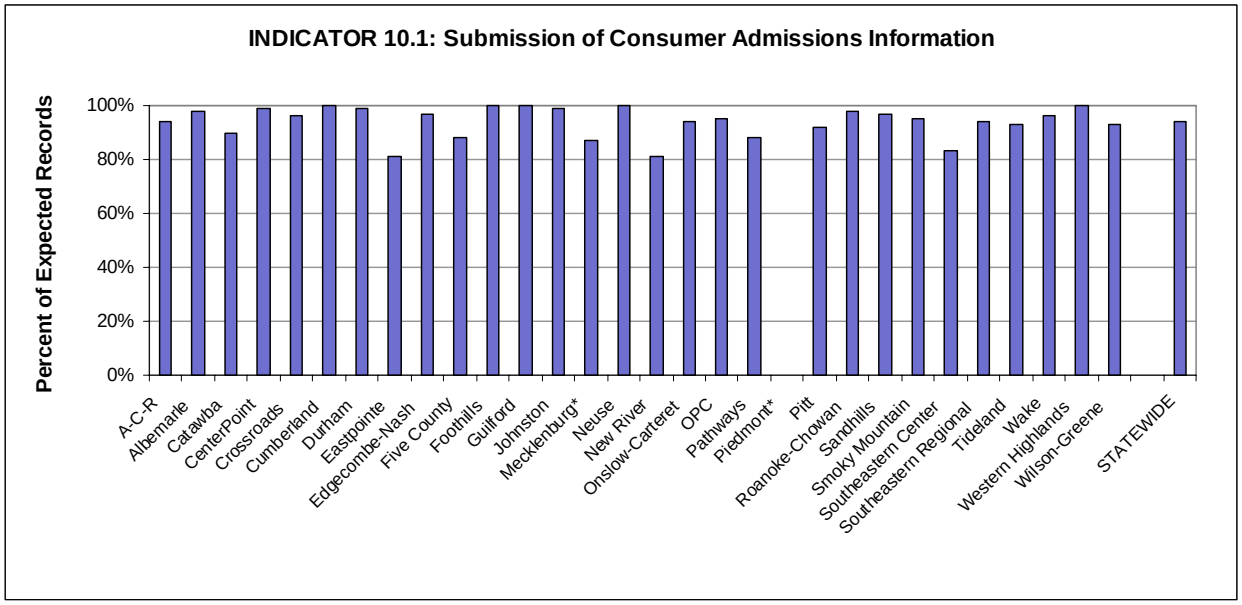
** Service claims data for Piedmont and Smoky Mountain are not available for this report. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[36] The numbers exclude funds processed outside of the Unit Cost Reimbursement (UCR) system.

Indicator 10: Effective Management of Information

10.1 Consumer Admissions

Rationale: Efficient flow of information is vital for effective decision making and oversight of a complex service system. Timely submission of consumer information is a gauge of the management and coordination capacity of the local system and the technological resources available to support it.



SOURCE: Consumer Data Warehouse Admissions Data (for admissions January – March 2006); Medicaid and State Service Claims Data. January 1 - September 30, 2006

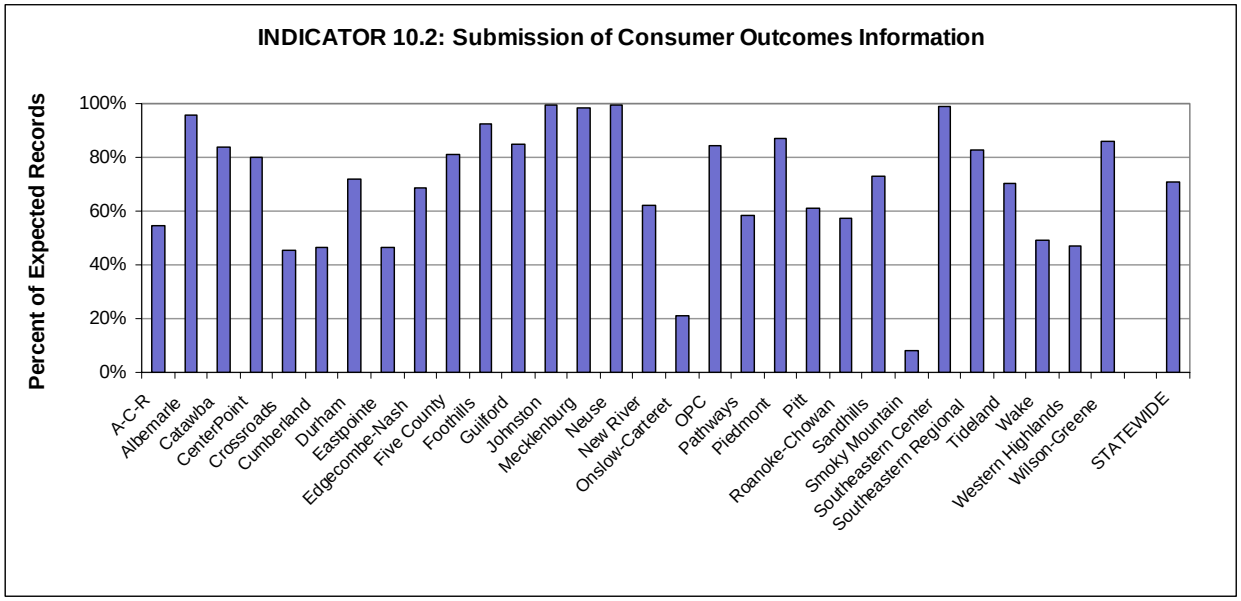
Statewide, the Division received identification and demographic information[37] on 94% of new consumers within 30 days of their admission to an LME. Submissions varied among LMEs from a low of 81% (Eastpointe and New River) to a high of 100% by five LMEs (Cumberland, Foothills, Guilford, Neuse, and Western Highlands).

** Piedmont data are not included due to problems in their information management system. Mecklenburg's numbers may be underreported due to problems in their information management system.*

[37] Consumer Data Warehouse Records Type 10 and 11.

Indicator 10: Effective Management of Information
10.2 Consumer Outcomes

Rationale: Efficient flow of information is vital for effective decision making and oversight of a complex service system. Timely submission of consumer information is a gauge of the management and coordination capacity of the local system and the technological resources available to support it.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. January 1 - September 30, 2006

Statewide, NC-TOPPS Update Interviews (due after 90 days of service) were submitted for 71% of MH/SA consumers who had an Initial Interview between January and March 2006.[38] The percent of expected Update Interviews submitted varied among LMEs from a low of 8% (Smoky Mountain) to a high of 99% (Johnston, Neuse, and Southeastern Center).

[38] Statewide, the Division received about two-thirds of the expected Initial NC-TOPPS Interviews for this period. This represents an improvement over earlier quarters of SFY 2005-06. Each LME's performance on submission of Initial Interviews is similar to their performance on Update Interviews, shown above.

Indicators in Development

Indicators in Development

Timely Access to Services

When an individual makes a request for service, quick response with the appropriate level of care is a gauge of the system's service capacity and coordination efforts. National standards for access include providing care within two hours of request in emergent situations, within 48 hours in urgent situations, and within 7 days in routine situations.

In January 2006 LMEs began submitting information to the Division on all persons requesting services. This data will be matched to service claims data to determine the percent of persons who received necessary emergent services within 2 hours of request, urgent services within 48 hours, and routine services within 7 days.

In addition, in July 2006, the Division began asking consumers whether or not their first service was in a timeframe that met their needs, as part of the Initial NC-TOPPS Interview.

Future reports will provide the results of these new indicators.

Person-Centered Service Planning and Delivery

Consumer recovery and stability hinge on designing community services to meet the needs of each individual. A timely, comprehensive service plan developed in collaboration with each consumer and the significant people in his or her life is crucial to designing and delivering individualized services. Increasing the number of consumers with person-center plans is a means to this end.

The LMEs are responsible for reviewing Person-Centered Plans (PCPs) for completeness and appropriateness and providing technical assistance to providers as needed. The indicator in future reports will show the number of PCPs reviewed by each LME, the number of those that needed revision, and the number for which the LME provided technical assistance.

Effective Oversight of Service Quality

Local oversight of community services is essential for risk management and continuous improvement of the quality of care. LMEs' assessment of their providers' strengths and areas of need can target technical assistance activities effectively. Increasing oversight to those providers with the greatest need for assistance improves the quality of the choices available to consumers.

Each LME is responsible for assessing its confidence in the quality of all providers operating in its catchment area and providing technical assistance and oversight to providers, as needed. The indicator to be included in future reports will show the percent of providers that the LME rated in the "low confidence" category and the percent of that group that the LME monitored or provided with technical assistance during the quarter.

The MH/DD/SAS Community Systems Progress Indicators Report and the Report Appendix are published four times a year. Both are available on the Division's website:
http://www.dhhs.state.nc.us/mhddsas/statspublications/index.htm.

Questions and feedback should be directed to:
NC DMH/DD/SAS Quality Management Team
ContactDMHQuality@ncmail.net
(919/733-0696)